**DEPARTMENT OF HEALTH AND FAMILY SERVICES** **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 1159 (Rev. 10/02)

# WISCONSIN MEDICAID
# OTHER COVERAGE DISCREPANCY REPORT

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

**INSTRUCTIONS:** Use this form to notify Wisconsin Medicaid of discrepancies between other health care coverage information obtained through the Eligibility Verification System and information received from another source. Always complete Sections I and IV. Complete Sections II and/or III as appropriate. Wisconsin Medicaid will verify the information you provide and update the recipient's file (if applicable). Attach any available documentation, such as Explanation of Benefits reports, benefit coverage dates/denials, or photocopies of current insurance cards. This will allow records to be updated more quickly. Type or print clearly.

## SECTION I — PROVIDER AND RECIPIENT INFORMATION

| Name — Provider (Last, first, middle initial) | Wisconsin Medicaid Provider Number |
|---|---|
| Name — Recipient (Last, first, middle initial) | Recipient's Medicaid Identification Number |

## SECTION II — MEDICARE INFORMATION

Medicare / HIC Number

| ☐ Add | | ☐ Remove | |
|---|---|---|---|
| ☐ Part A Coverage | Start Date | ☐ Part A Coverage | End Date |
| ☐ Part B Coverage | Start Date | ☐ Part B Coverage | End Date |

## SECTION III — COMMERCIAL INSURANCE INFORMATION

☐ Add ☐ HMO
☐ Remove ☐ Other

Name — Insurance Company

Address — Insurance Company (Street, City, State, Zip Code)

| Name — Policyholder (Last, First, Middle Initial) | Policy Number |
|---|---|
| Coverage Start Date | Coverage End Date |
| Recipient Left HMO Service Area ☐ Yes ☐ No | Date Recipient Left HMO Service Area (If Applicable) |

## SECTION IV — REPORT INFORMATION

| **SIGNATURE** — Individual Completing This Report | Date Signed | Telephone Number / Extension |
|---|---|---|
| Name — Source of Information Included on This Report | | Telephone Number / Extension |

| Mail to | Fax to | Comments |
|---|---|---|
| Wisconsin Medicaid<br>Coordination of Benefits<br>6406 Bridge Rd<br>Madison WI 53784-6220 | Coordination of Benefits<br>(608) 221-4567 | (Please continue any additional comments on the back of this sheet.) |

Reset Form